Compendium of Steering Committee Comments Pursuant to Meeting on September 17, 2013

The Core Team requested feedback on the materials presented to the steering committee meeting held on September 17th, with particular interest in the following areas:

1) Recommendations for alignment on standards (slide 8)

2) Questions related to linkage between care delivery and payment reforms (slide 18)

   a) Should timing of migration to Shared Savings Program (SSP) arrangements be decided by each payer and provider, without regard to progress on standards or AMH status? This is currently our preliminary recommendation for several reasons. The first is that is already happening today among the commercial payers and Medicare and it seems unrealistic to propose to undo existing payment arrangements. The second is that having payment reforms such as shared savings programs in place actually makes it possible to achieve certain elements of practice transformation (e.g., replacing some visit based activity with phone and e-mail communication, which can increase access and generate revenue through shared savings, and third, the possible effect of slowing entry into shared savings arrangements and thus losing the support of payers and some providers.

   b) Should there be a validation survey that all existing and future providers would be required to meet as a condition for remaining in SSP arrangements?

3) Proposed Governance and operating model (slides 24-27), support for establishing the four proposed advisory councils/task forces and proposed composition

4) Pace of payment reform assumptions (slide 31)

5) Options for scaling provider transformation support and care coordination funding (slide 32)

Comments and our responses are summarized below.

Topic	Comment	Response
T. Raskauskas, MD		
A1. Quality matrix	All the commercial insurers are currently entering population health contracts with provider groups. I suggest be presented to the steering committee with the metrics from each carrier, as well as Medicaid and Medicare to see where current commonality exists. The committee can then look to where there is diversion, and suggest CT common metrics.	The Core Team supports this recommendation, although we would suggest that this be part of the scope of work of the Quality Advisory Council, perhaps with report back to steering committee for input (or approval). CMMI is also requiring that their recommended metrics be a priority for inclusion in the core measurement set.
A2. Linkage between care delivery and payment	a) Currently, there are 11 organizations in the state that have been recognized by Medicare as shared savings. Additionally, the commercial payers are contracting with some of these same organizations in population health contracting. Each of the commercial payers has developed readiness assessment tools for groups, and Medicaid has a readiness assessment for PCMH. NCQA and URAC both have standards for clinically integrated networks/ACOs as well. I suggest pulling all the tools together, looking at common elements, and then seeing where there are differences.	The Core Team supports this recommendation, although we would suggest that this be part of the scope of work of the Provider Transformation Task Force, perhaps with report back to Steering Committee for input (or approval).
	b) Reimbursement with the commercial market is restricted to upside shared savings only. To accept downside risk, there should be input from the Connecticut Insurance Department, as this requires financial reserves and other issues that	We will examine this issue in November with CID when we inventory statutory and regulatory changes necessary to support the SHIP, recognizing that CID regulates only a portion of this market.

	go beyond population management, but more closely align with insurer requirements of financial capabilities.	
	c) I suggest that groups/networks entering into population health contracting under the SIM model complete readiness assessment tools.	This recommendation has been included in the plan.
A3. Governance Models	Governance models - I am concerned with the development of 4 new departments, and how funding would be provided for each. Can these functions be brought under current operations within existing state departments?	We are not proposing to establish new state agencies or departments. The Task Forces/Councils are vehicles for obtaining multi-payer, provide, state agency and employer alignment in the four areas identified, with consumer/consumer advocate participation and input. The task forces would provide additional public transparency in these important areas. For example, the provider transformation task force will recommend AMH standards. The payers will be responsible for adopting and implementing those standards. Meeting frequency would likely be greater during the pre-implementation phase and perhaps quarterly thereafter. Additional detail will be provided in the draft SHIP, although task force charters may not be developed in time for inclusion in the SHIP. The role of the Oversight Committee would be to provide high level oversight of the implementation of the SHIP. This would be similar to the current Steering Committee's role as it pertains to the SHIP

		development.
A4. Pace of Reform	Pace of payment reform in the state-I feel this slide better represents where the state currently is. There are 11 entities recognized by Medicare for shared savings program, and there are similar numbers of organizations with population based contracts in the state. This does not mean to say there are not a number of 1,2 and 3 independent provider practices; it demonstrates how these practices have linkage to entities that have resulting in population health contracting, and can tap into central process that the small practices cannot provide.	Input noted.
A5. Options for Scaling Practice Transformation Support and Care Coordination	Provider transformation support-there is still quite a bit of work to bring more practices onboard with electronic prescribing, EMRs, and PCP practices transforming to PCMH. I suggest using funding for a survey in year 1 and year 5 to establish a baseline and follow up of where providers are with implementing e-prescribing, electronic records, PCMH, and involvement in a contracting network. Additionally, which providers consider themselves actively seeing patients, and acting as PCP or specialist. This would be very helpful in terms of where Connecticut is, and an evaluation of where we are at the end of the project. Results from such a	We concur with the recommendations for a method of assessing our progress on practice transformation, and this will likely be required by CMMI for the purpose of self-evaluation. A survey will be considered, probably at intervals more frequently than beginning and end. However, survey responses tend to be limited and thus unreliable. We will explore alternatives, including whether the on-line physician licensing process can be modified to support assessment of these key indicators of practice transformation.

	survey could also provide information as to the need for funding based upon the numbers of providers lacking some basic infrastructure as noted above.	
F. Padilla		
B1.	I would like a deeper discussion of the population level health outcomes that the advanced medical home model is intended to produce. We need to start every discussion with the results we intend to achieve through SIM, and they must begin with population level results.	The Quality Advisory Council will set specific outcome targets, drawing from CMMI's recommended measurement set and other measurements sets such as those endorsed by NQF. Specific attention will be paid to metrics that align with Connecticut's health equity gaps. Primary care transformation and associated payment reforms alone are unlikely to improve the health of communities. We are proposing an additional strategy which we are referring to as Community Health Improvement focused on improving overall public health.

B2.	Relative to standards, I don't see why we should create our own standards. I agree with others who have commented, that we should look at NCQA and other standards already being complied within CT and identify where there are gaps that we should fill with CT's own value-added standards	We are not proposing to develop or create Connecticut standards but rather to take a best of breed approach to compiling a set of standards that already exist. There may be some tailoring of these standards, and the possibility exists at a new standard might be established where none exist. The rationale for this approach bears further elaboration. Providers and payers in Connecticut now have several years of experience with the NCQA PCMH recognition process. Many providers report that meeting NCQA or other national standards is both costly and administratively burdensome and that recognition or accreditation does not necessarily result in practice transformation. They have also indicated that the time and effort spent on the administrative requirements of a national accrediting body such as NCQA would be better spent on the transformation process. Payers for the most part share this view. In response, they have developed their own standards and tools for assessing a provider's "readiness" to function as a medical home--to provide better integrated and coordinated care and to enter into contracts that hold the provider accountable for quality of care and care experience. Each payer has its own standards, many of which are similar to those of national accrediting bodies such as NCQA.

		Under SIM, we are proposing to introduce a common set of standards that would be adopted by all payers. Providers will have an easier time undertaking transformation, if there is a common set of standards that all payers use or recognize. The standards will draw from existing national standards, recognizing that each of the national standards today has strengths and weaknesses. For example, one of the most widely used medical home standard sets is weaker in the area of population health management. In this area, we might decide to base our population health management standard on those of another accrediting body. We might then enhance this standard to ensure that it allows for the identification of health equity gaps among various race/ethnic groups. Our SIM practice transform support will be developed around these standards. We envision that the practice transformation support vendors will also assess readiness through a validation survey. Payers would have the option of accepting this validation survey, or continue to rely on their own readiness assessment. In either case, the practice is only having to demonstrate compliance with a single set of standards established under the SIM multi-payer alignment process.

B3.	I would like to know more about the practice transformation glide path and the support practices will receive to achieve that transformation. Slides 18 and 19 outline a very ambitious plan for workforce development. Practice transformation goes far beyond technology. Practices will require training and development of existing employees for this new model of care. What kind of new positions will the functions of the advanced medical home model call for? What kind of cultural transformation will be needed and what types of supports will be in place to facilitate it? Unlike several other states, Connecticut does not have a PCMH learning collaborative in place. If SIM is saying we need one, (which we obviously do) how will this crucial work be supported early on in the process, before the new payment mechanisms have kicked in? Another example of the need for earlier investment would be in the development of the community health worker role and putting CHWs in the community and/or connected to practices. Again, it is unclear how we will actually be able to move forward to make sure that there will be sufficient dollars initially to support community-based workers and structures. I think this kind of information should be factored in to determine whether the assumptions on slide 31 are realistic.	We anticipate that the practice transformation process will support practices in a range of ways, depending on the standards and elements established by the practice transformation task force. The task force will also be charged with advising on the specific transformation processes. These may, for example, include EHR adoption, meaningful use, practice workflows, use of payer or practice analytics to support health risk stratification and population management, team-based approaches and support for hiring and training care coordinators. We anticipate that the practice transformation will be provided to cohorts of primary care practices who enter the glide path at the same time and whose practice gaps are similar. Members of a cohort will participate in a learning collaborative process facilitated by the practice transformation vendor. We believe that the payers will agree to fund or otherwise recognize the cost of care coordinators, but we do not yet have support for funding community health workers, pharmacists and other members of the envisioned health care team, except to the extent that these individuals might be providing care coordination. The expansion of the primary care team beyond care coordination is not required by current medical home accrediting bodies, and this should not influence the

		pace with which providers can advance to medical home standards, nor the pace with which they are able to enter into value paced payment methods as depicted on slide 31.
B4. Role of non-physician providers	Another workforce issue that is not addressed directly is the crucial role that will be played in the new team-based practice environment by nurse practitioners, physician assistants and other allied health professionals. Where in our thinking are we providing for consumer/patient education of the "new face" of the health care workforce, that you don't always have to see the doctor and that there are highly trained, skilled members of the team that will be caring for you?	We recommend that the expansion of the primary care team be phased in over the five years of the grant, with a focus on care coordination in the first 2 to 3 years, along with pilot initiatives examining the return on investment for new roles on the primary care team. Consumer education has been a focus of more recent discussions with stakeholders. We are considering devoting some funds to the development of educational materials for consumers about the changing primary care practice environment, but also about their changing role, a more empowered role at the center of person centered planning, one in which informed choice and shared decision making will play a central role. Such tools may be developed for use by employers, health plans, primary care practice settings, and within adult education programs.

B5.	While I understand that replacing some visit-based activity with phone and email communication, and other similar elements of practice transformation may generate savings and increase access to care, especially in certain parts of the state where there are provider shortages, I think we must consider the unintended consequence that we reinforce a two-tier health system where patients feel like second class patients. In the interest of generating savings, changing the expected in-person appointment to an albeit more effective phone or email communication may in fact exacerbate the real or perceived discrimination in health care which translates to inequity and disparity.	We agree that a medical home approach should not be a one-size-fits all approach and that methods of engaging consumers need to consider individual consumer needs and preferences. The assessment of care experience and inclusion of care experience performance as a basis for value-based payment should mitigate against one-size-fits-all in favor of consumer engagement processes that are sufficiently flexible to meet the needs of a wide variety of consumers and result in higher levels of consumer satisfaction. We intend to continue our practice of listening to consumers through focus groups and other methods to learn from patient perceptions so that we understand how changes in the care model can best be communicated in the patient education process and incorporated into quality improvement processes.
B6.	Slide 18 – I include a link here to Michael Porter's excellent piece, "What is Value in Health Care?" http://www.nejm.org/doi/full/10.1056/NEJMp1011024 Porter writes, "Value is neither abstract nor a code word for cost reduction. Value should always be defined around the customer, and in a well-functioning health care system, the creation of value for patients should determine the rewards for all other actors in the system." I share this quote to say that I think we must be careful and attentive that the goal of our SIM	We agree with your central point that "we must be careful and attentive that the goal of our SIM plan should be transformation of the system to produce better outcomes for consumers, and that the model of care and payment align to support that result." And we believe that's where this model will take us, recognizing that our success will depend on thoroughness of planning and quality of execution. On the question of bundles, the care delivery and payment reform workgroups considered our readiness

	plan should be transformation of the system to produce better results for consumers and patients, and that the model of care and payment align to support that result. Porter argues that costs may be ultimately controlled in many ways. In some cases that may mean that we pay more for certain services in order to save on others, and that we must look at the health care results for whole "bundles" of services any particular individual or patient group may require. Cost reduction and financial sustainability is critical but we may not realize that either if we don't maintain this focus on outcomes and the benefit to the consumer. With regard to the timing question in slide 18, why should providers begin to benefit from shared savings before they've demonstrated adherence to standards? On the other hand, providers need support to make the needed changes and right now the current fee for service system doesn't provide that support. We need the timing to be both a push and a pull to help with transformation	to implement bundled or episode based payments. They felt that these methods will play a critical role as an overlay to population based methods such as shared savings programs. However, population based methods provider an important foundation and can be achieved for 80% of the population in the proposed timeframe. It is important to recognize that the payers who have proceeded down the path of shared savings and cost accountability (e.g,. Medicare ACOs and commercial payers) have established care delivery standards, readiness assessment processes and quality targets. So providers do demonstrate adherence to standards before benefitting from shared savings. SIM offers the opportunity to align and enhance those standards across payers, bring some consolidation to the readiness assessment process, and to continuously improve the quality and care experience metrics that serve as the basis for shared savings rewards. We also agree that providers need support to make the needed changes and that current fee for service system does not provide that support. For this reason, we are proposing to allow for some flexibility with regard to payers and providers decisions to proceed with payment reforms alongside migration toward meaningful and demonstrable practice reforms.

B7.	Proposed governance model: The model is designed to provide oversight and guidance to the advanced medical home implementation. What about the payment reform implementation? Where will accountability for that sit? The payment reform elements of SIM are in support of the delivery system innovations. These two elements must be kept coupled in the governance. Consumer advocates and consumers must be an integral part of the governance model, from the Health Care Innovation Oversight Committee (and the Health Care Cabinet Consumer Advisory Board, by the way) through each of the taskforces/councils. There should be a payment task force and a workforce development task force as well. This entails a lot of work, and it is essential that the SIM implementation be fully supported by a complement of highly-qualified staff	We are proposing that accountability for the payment reforms will rest with the Project Management Office and Oversight Committee. We will also consult with the Health Care Cabinet and the Health Care Cabinet's Consumer Advisory Board, which we will add to our proposed chart of governance. We agree that consumer advocates should participate in the various task forces and councils. The purpose of the Task Forces and Councils is discussed in our response to A3. We do not believe that every task or work stream requires its own task force or council and these councils are not charged with the task of planning and implementation. The Project Management Office will be charged with implementing the various work streams and will need to be resourced with individuals with the qualifications to do so.
Comm Rehmer		
C1. Recommendations for alignment on standards (slide 8)	• Agree that Transformation Workgroup defines AMH standards and elements (perhaps with new language of Enhanced Health Community) • Agree that payers participate in workgroup and voluntarily adopt standards • Agree on reciprocity with accreditation bodies • Agree on selected vendor doing onsite	No Response

	validations	
C2. Questions related to linkage between care delivery and payment reforms (slide 18)	a) If providers could migrate to SSP without regard to progress on standards, we would be concerned about ensuring access for high risk clients, i.e., "cherry picking." How do we guard against this? b) Yes.	The issue of "cherry picking"….avoiding new high risk clients or discharging high risk clients…is not something that can be adequately addressed through standards. Instead, we are proposing the creation of a separate task force that will be dedicated to promoting payers' adoption of analytic and other methods for preventing or reducing the risk of cherry picking.
C3. Proposed Governance and operating model (slides 24-27)	• Continue DMHAS Commissioner representation on Healthcare Innovation and Oversight Committee • Change name to the Healthcare Equity and Access Council (drop appropriateness). DMHAS would want representation on this council. • Support the addition of a Workforce Development Council	The DMHAS Commissioner will be represented on the Oversight Committee. We are considering options for naming the Equity, Access and Appropriateness Council. We support the recommendation for DMHAS -representation on this Council. This recommendation is under consideration and will be a point of discussion with UConn, DPH and the steering committee. The workforce work stream is a set of fairly diverse initiatives, which may be better managed through distribution to existing entities and planning bodies, with high level oversight by the Project Management Office and the Oversight Committee.
C4. Pace of payment reform assumptions (slide 31)	No disagreement	Response noted.
C5. Options for scaling	No disagreement	Response noted.

provider transformation support and care coordination funding (slide 32)		
Dep Comm Dowling, CFA		
D1. Impact on workforce environment	a. Will this structure appeal to new graduates?	We believe the answer is yes, but we are eager to hear from providers when we present the model to a broader audience for feedback. During the SIM planning process, we heard from many primary care providers who described the current work environment as unrewarding due to the extraordinary pressure on productivity and limited reimbursement. Our aim is to transform primary care practice into a team-based approach that should lessen productivity pressures on any one team member. The emphasis on collaboration and quality improvement may also lead to a more rewarding experience for providers. CT's SIM initiative is part of a national change process stemming from the Affordable Care Act and that similar advancements and designs are being implemented across the country. We expect that these advancements in care delivery will soon become the 'new normal' for healthcare providers across many disciplines and settings In support of this view, according to a recent article in Health Affairs, "the use of non-physician professionals

		to deal with more routine problems and the decreased need to respond to urgent requests for care that comes with shared practice can increase the attractiveness of primary care careers for new physicians, adding to the forecast supply. In fact, recent data suggest that this trend may have already begun. The number of graduating US medical school students who will enter primary care specialties increased for the second year in a row in 2011, according to the National Resident Matching Program. The number of M.D. seniors in the US matched to family medicine positions rose by 11 percent over 2010 levels." (Green, Savin, and Lu, 2013, pp 16)
	b. Will we attract or lose our medical school graduates? Why?	According to the Connecticut State Medical Society, there are a number of obstacles that they believe discourage students from pursuing primary care and doing a residency or setting up a practice in Connecticut: • faculty discourages primary care • faculty encourages residencies in large facilities where these are more professional opportunities • CT has the 3rd lowest patient-physician ratio in the country. The problem is maldistribution; leaving opportunities in "undesirable" areas in the state (low income, poor resourced communities and professional isolation • Cost of living, poor schools, lack of cultural offerings

		across the state • Schools of Medicine take students from all over the world, so CT isn't home to at least half of them in the first place • Physicians donate their time in free in clinics and as preceptors/mentors for their philanthropic activities Tuition reimbursement programs working in medically underserved communities (NHSC) are vacant (more than half in the state) because of the high stress, low resourced environments (clinics, CHC). Those that complete the program don't stay in medically underserved areas. AHEC was working on an evaluation project although we do not have the results. These problems are not unique to CT but we don't have draw to attract young physicians and haven't been able to keep our young physicians. Quinnipiac's goal for primary care is only 30% of student body staying in CT for their residency. We have been told by medical students in one of our stakeholder meetings that Connecticut' cities are not a draw. If they're going into residence in the Northeast, they said their peers prefer to be near Boston or New York. This would seem to be a minor factor, but it was their focus in our stakeholder interviews. We believe that continued work is needed to develop our SIM strategy related to this issue.

D2. What is the value added of SIM?	What are we offering on the margin with this structure versus the way the commercial payers, hospitals and provider groups are migrating toward anyway?	Hospitals and provider groups are migrating in this direction, however, SIM is offering benefits that should streamline and accelerate the process of transformation. A few of these benefits are as follows: 1) Alignment on common set of medical home standards 2) Alignment on a single provider portal rather than the multiple that exist today 3) Alignment on quality and care experience metrics and a balanced scorecard 4) Potential alignment on the provision of payer analytic health risk stratification data to support ease integration into the practice systems and workflows. 5) Alignment on payment of care coordination fees or other allowance for these costs across all payers, which supports the overall cost of hiring

		and deployment, which means not having to provide the service free of charge or withholding coordination for non-participating payers. 6) Access to a shared utility within the community (Community Entities), evidenced based secondary prevention services with attention to the social and environmental determinants of health. It is also important that we are proposing practice transformation support. There is a common misconception that demonstrating readiness and simply moving into these value based payment arrangements will substantially change practice and result in better outcomes. The report from stakeholders in Connecticut is that meaningful, sustained changes in practice and continuous improvement in quality are the exception rather than the rule, even for practices that have attained NCQA recognition. Nationally, a number of Pioneer ACOs have failed to achieve targets and experts at CMMI and SHADAC noted that this was due in part to a failure to succeed in transforming care. For this reason, we are proposing to make these supports widely available, supplemented in part by SIM grant dollars, and to ensure that follow-up and validation processes are in place. In addition, we are proposing an assertive outreach and engagement campaign with the 40% of primary care

		providers who remain uninvolved in practice transformation and value-based payment. Some of these practices will affiliate with larger systems in the next few years, but primary care transformation for these same practices promises to occur on a much longer timeframe without our assistance. Finally, questions have been raised as to whether and to what extent we will grant reciprocity to providers who have been recognized or accredited by a national body such as NCQA. We anticipate partial or whole reciprocity will be granted, depending on the degree to which the SIM proposed standards align with national standards. We would like the Provider Transformation Task Force to review this question and make a recommendation, once standards have been established.

D3.	Since migration to a SSP is unique to the circumstances, practice, specialty and patient volume (and therefore financial strength) of each group, a pre-determined schedule may be premature for some who cannot afford the risk. It should be based on the achievement of certain quantifiable measures that are common to any funded investment.	The migration to a SSP will be determined by individual payers and providers based on achievement of measures of readiness, rather than a pre-determined schedule. At present, there does not appear to be an issue of management of the risk because none of the existing arrangements have downside risk. We are interested in CID's view as to what statutory or regulatory changes would be needed, if any, for IPAs, clinically integrated networks, and ACOs to bear downside risk.
D4. What are we learning from carrier's reform efforts to date?	If we skip to the factor with the heaviest determinant for success or failure, the funding of such investments, we know the commercial carriers have designed entire departments dealing with value-based models. Each has a spectrum along which provider groups or ACOs progress financially based on financial strength and quality outcomes. Have we asked the national carriers what has made the Connecticut environment a bit slower than other in moving along the spectrum? I suggest a lot of good research has been done that we need not reinvent and that we could learn from.	Good question. We have inquiries out with several of the carriers and will share their comments when we receive them.
D5. Are we enticing PCPs?	What have we done to entice PCPs to aspire to take this financial risk? What is our competitive branding to attract and retain providers to CT?	Many PCPs are pursuing affiliations or joining networks and are prepared to participate in value based payment reforms. These reforms are primarily shared savings

		programs with gain share, and no financial risk. With regard to true downside risk arrangements, we need to consider the impact on quality and whether the regulatory environment will allow this for commercial payers and self-funded employers. Medicaid and the OSC have not yet signaled whether they intend to pursue downside arrangements. Medicare entices providers to accept downside risk in the future in return for higher gain share opportunities. Commercial payers may pursue a similar approach. We are proposing that the negotiation of such financial arrangements be left to individual payers and providers. With regard to competitive branding, we believe that primary care as practiced in today's fee-for-service environments are not attracting primary care providers. Value based payment reforms offer the opportunity to improve the experience of primary care practice, with less of a focus on generating volume. These include team based care, learning collaboratives and the rewards of using more tools to be effective, such as population based management and continuous quality improvement. In addition, payment reforms offer the opportunity to enhance practice revenues and physician reimbursement. Failing to keep pace with other states in this area will likely further impede our efforts to attract and retain primary care providers.

		There is more for us to learn about how medical students and residents decide where to take up practice as noted in our response to D.1.a. As we move forward, we need to carefully consider the branding and marketing of our CT SIM support offering, perhaps with the option of retraining professional marketers to consult in the design our approach.
D6. Is another assessment viable?	One time grant options will be good seed capital, but as to longer term sustainability, ……We assess insurance carriers over $90 million today (Insurance Fund, OHA, DMHAS, immunizations, and ,soon , AHCT before premium taxes . Is adding another assessment a competitively viable option?	A related question is whether we can achieve the necessary investments without applying additional assessments, whether on carriers or providers. Are there other sources of funds that can be redirected if we are able to achieve the envisioned savings targets.
D7. Governance and operating structure	Now for the really ignorant question: what is the proposed governance structure governing differently than existing agencies, both State and Federal? What teeth does it have as it is not a licensing body for providers, hospitals or payers?	The proposed governance structure including a dedicated project management office provides the means to undertake a large project centered on multi-payer alignment in the areas care delivery, payment, HIT and workforce reforms. The management of a multi-payer process (including self-funded employers) transcends the role of any existing agency, but it does not supplant the roles and functions that fit squarely within the scope of existing agencies, or functions that could be strengthened to undertake certain elements of the project more efficiently.

		Most of the payers have committed to collaborate in the way envisioned in the SHIP without statutory or regulator inducements. We believe that providers will also be attracted to participate for the reasons noted earlier. However, we remain open to the identification and use of policy levers as part of the current plan, or as options for future consideration.
D8. Will SIM oversight be unwelcome to providers?	What might adding more oversight in Connecticut do to our competitive position for providers?	We believe that providers will, on the whole, appreciate the support provided by SIM and the effort to align payers. The oversight will be directed primarily to the activities of payers and provider systems, rather than individual practitioners. It isn't clear that the oversight proposed would be unreasonable or burdensome relative to other states, however, we anticipate learning more on this question when we circulate the draft plan for comment. We will be holding webinars with practitioners to raise awareness and invite discussion.
OPM Comments		
E1. Recommendations for alignment on standards (slide 8)	No issues	Response noted.

E2. Questions related to linkage between care delivery and payment reforms (slide 18)		
a)Should timing of migration to Shared Savings Program (SSP) arrangements be decided by each payer and provider, without regard to progress on standards or AMH status?	Makes sense to build on what is currently going on. However, there should be some mechanism to track progress on standards or AMH status	Our evaluation will include a method for tracking progress on AMH standards and also the pace of payment reforms. The mechanisms for doing so remain to be determined.
b) Should there be a validation survey that all existing and future providers would be required to meet as a condition for remaining in SSP arrangements?	We were under the impression that there would be shared standards (slide 8), and that the payers would each implement them independently, using their own models	The payers do not routinely do validation surveys and there is broad consensus that a policy requiring on-site validation survey or the equivalent is essential for achieving meaningful transformation. We could rely on separate validation surveys conducted by each payer on each practice, but this seems less efficient than co-sourcing a vendor to do so once for each practice on behalf of the payers. Not all payers would use the option of a co-sourced vendor.

E3. Proposed Governance and operating model (slides 24-27) Support for establishing the four proposed advisory councils/task forces and proposed composition	Model and task forces OK – not sure what the state role is here.	See responses to A3, B7, D7 and G8.
E4. Pace of payment reform assumptions (slide 31)	To achieve near universal payer participation, a high level of provider participation and cover 80% of CT residents in 5 years does not seem that realistic, considering that this is all new territory and it is unclear who are willing participants. Are we setting ourselves up for failure?	CMMI established the goal of 80% as a requirement of the SHIP and, based on what is happening in the market today, we believe this goal is achievable. We have in our favor an agreement among all of Connecticut's payers to support these reforms, and we have increasing support for these reforms among major business groups such as CT BGH, NE BGH and CBIA, such that we believe both fully insured and self-funded employers will eventually support our plan. We also have a considerable pace of consolidation in the primary care market in a very short period of time (i.e., 24 months). This consolidation takes the form of affiliations with IPAs or larger integrated networks, or actual practice acquisition. While consolidation does not equate to better quality, this consolidation is necessary to support investments in shared infrastructure and capabilities amongst practices and in

		the ability to participate in advanced payment reforms. Finally, we have strong medical home programs on which to believe and a relatively widely held belief among primary care providers that advanced primary care is the way of the future. Our biggest challenge will ensuring that a) we achieve meaningful reforms in practice beyond medical home recognition and necessary to improve quality over time, and b) that we are able to engage the practices that thus far have shown little interest in practice transformation. In the latter case, it will be essential that we provide a persuasive message to market transformation, an attractive package of transformation supports, and a clear, achievable path for getting there.
E5. Options for scaling provider transformation support and care coordination funding (slide 32)	Who pays for this investment?	A budget and source of funds is not yet complete. It is anticipated that the investment will be supported by a combination of CMMI and private foundation grant funds, payers, providers, and the state. There may be elements of the plan for which we do not have a source of funds on implementation. In this event, we will need to continue to seek new sources of funds, phase in certain elements of the plan more gradually, and/or scale elements down to serve as pilots.
Commissioner Mullen		

F1. Governance and Operating model	Make it a priority that the composition of the suggested Provider Transformation Workgroup includes a diverse set of stakeholders –mid-level providers as well as MD's, and those who represent a variety of practice settings, including community health centers, that address the needs of Connecticut's increasingly diverse population.	Recommendation noted.
F2. Duplication of functions	On the proposed Governance and Operating model, ensure that SIM is not duplicating entities/functions that may already be in existence in the state to avoid bureaucratic frictions.	As we develop a more detailed project plan and project management office (PMO) structure, we will consider opportunities to enhance line agency functions to lead in certain areas to avoid building duplicative or conflicting capacities in the PMO.
F3. Task force representation	Include CT DPH as well as representatives from local health departments in the proposed metrics and governance workgroup/taskforce.	Recommendation noted.
	Health equity needs to be a cross cutting priority in our SIM initiative. One way to achieve health equity through our SIM effort may be through supporting and promoting community based programs and partnering with local health departments	Recommendation noted. We are looking at equity opportunities in AMH standards, quality measurement, equity monitoring through the Equity and Access Council, workforce, and our discussions with DPH regarding community health improvement. More detail will be included in the draft SHIP.
F4. Substance behind aspirations	I appreciate and concur with Pat Baker's comments that there must be more substance behind the aspirations.	Recommendation noted.

P. Baker	(For additional comments, see Attachment)	
G1. Model must define what and how	The framework is aspirational and one many can support, but the design must represent a model not just aspiration. There is a need for more clarity on **what** and **how**. I would suggest that one reason we have struggled so is that we tackled some of the means such as payment reform without clarity of goals and objectives. Without clarity of these goals and objectives, the plan can be misinterpreted and the reviewer will read into it their perspective or assumptions, and one can think there is buy in when there is not	Understood. We anticipate that the SHIP and associated driver diagrams will provide additional clarity with respect to what and how. It is important to recognize that we are intentionally non-specific in areas such as AMH standards, quality targets and metrics, and methods for ensuring equity and access as these questions are central to the work of the proposed task forces and councils.
G2. Key questions/ detail	I suggest that we need to address key questions in future presentations: o What should the delivery system look like- from continuum of care to connection to community? o What are the key issues that require attention and how will the system design address key issues? o How do consumers define their needs across sub-populations, including racial and ethnic populations, and how will the new system better meet those needs? o How would care be organized and delivered in a multi-payer arrangement? o What standards will guide the delivery of care particularly for populations of color?	Recommendation noted. The SHIP and accompanying documents should provide substantially more information in most of the areas that you noted. Consumer defined needs appear to be differently prioritized for safety net populations versus non-safety populations. We expect that our emphasis on disparities based on public health information will additionally track and address concerns of inequalities based on race and ethnicity.

	o What is the self-evaluation- how are we judging success? o How will the system promote improvement in quality in a manner that offers better value without harming health outcomes or access? o What is the accountability and quality improvement function beyond reporting? What are the data sources that can most readily support SIM? How are we supporting providers to do their best work? Are we consciously building the APCD to perform key activities including identifying providers whose practice patterns indicate consistent over- or underutilization or quality results. o What are the means of addressing systems glitches or individual providers that compromise access and care particularly for the most vulnerable?	

G3. Why not use national medical home standards	Standards already exist and are being used in CT and nationally to enhance primary and preventive health care delivery settings. Rather than devising entirely new standards isn't it better to build on what exists rather than add one more acronym to the soup. In particular, NCQA includes specific standards to address health equity – as well as general standards that can be honed to address disparities in health care delivery see attached chart.	See response to B2 above.
G4. Continuous quality improvement	Building in CQI as the way CT does business explicitly including patients/consumers in this practice will serve as a critical mechanism for ongoing transformation and ground the system to reality	The Project Management Team intends to gather and learn from consumer input ongoing throughout the implementation by means of our self-evaluation, which will be detailed further in the draft SHIP. This is a process that we believe is also important to undertake at the provider level. Continuous quality improvement around care experience and outcomes will be a focus of provider transformation and rewarded through the value based payment methods.
G5. Equity and Access Council	I applaud the Equity council and its construct, but beyond this council, there must be a rigor and timeliness applied to ensure that care is not being limited or made more difficult in order for any entity to enjoy greater financial reward. Rather if we can engage in a process that allows various constituencies to have input in what is	Indeed the Equity and Access Council must foster rigorous and timely methods for monitoring practice variations that might signal under-service. We will be examining options for retrospective and concurrent review. Equally important, consumer advocates will be invited to participate in the Quality Advisory Council where recommended core quality metrics will be

	being rewarded, the long term objective of transformation is more likely. Ultimately we want improved health outcomes which is what should drive the reward system.	defined and expanded over time. It is our intent that payers adopt these quality metrics as the basis for rewards. Moreover, the recommendations of the Quality Advisory Council will be presented to the Consumer Advisory Board for input. However, the proposed payment reforms emphasize more than outcomes and rewards from improved outcomes. The rational for total cost of care accountable payment methods is to reward providers who find innovative ways to reduce waste, inefficiency, and the unnecessary services that sometimes harm consumers. Improving outcomes is a central tenet, but not sufficient to change the market to delivering better value.
G6. Concerns about total cost of care accountability	Total Cost of Care alarms many with concerns that the outcome of pursuing reduction in total cost of care is denial of care to those most in need. If we are basing our cost savings on the findings of the IOM report on unnecessary costs then any proposed financial modeling and proposal should demonstrate how CT proposes to mitigate the sources of waste identified in the IOM report as opposed to what can happen- denial of care or under-utilization	Total cost of care accountable payment reforms, whether population based or episode based, are not simply about the elimination of waste. These reforms are among the few approaches that change the market by incentivizing every participant in the supply chain to offer not simple the most effective care, but the highest value care. This includes specialty services, medical equipment, pharmacy, home health and many other elements of the market. We believe that the proposed value based payment methods will spark innovation in the reduction of waste, but also in greater efficiency and value of every service or procedure offered by health care providers. Admittedly, there is a risk of under service, but today's system rewards over service, in-

		effective service, and sometimes harmful service. There are methods that can be employed to guard against under-service and we are proposing to put these methods into place alongside the payment reforms. Program integrity functions that focus on these issues of risk avoidance and under-service should be separate and apart from quality measurement and continuous quality improvement activities. To this end, we are proposing to establish a separate Equity, Access and Appropriateness Council, comprised of consumer advocates, payer-based experts in audits and advanced analytics, and clinical experts and researchers from the state's academic health centers. The task of this Council will be to recommend an audit strategy and methods, both retrospective and concurrent, that will help guard against these risks and to encourage payers to adopt such methods on or before implementation. The state anticipates that payers will expand or repurpose existing audit resources to support the recommendations of this council.

G7. Consumer involvement in decision-making	Consumers need to be at the table at all levels of decision-making. This proposal posits changes not just for the provider but also the consumer- how do you gain understanding and engagement without the grounding of consumers?	Our plan includes a broad range of consumer empowering strategies including participation in a consumer advisory board, ongoing measurement of consumer experience, and importantly, tying the consumer view to value-based reimbursement. We are also considering strategies to engage consumers in their communities, similar to the strategies being employed in the navigator and in-persona assister programs in AHCT. We recognize that the best way to engage consumers, beyond participation in work forces and councils is to engage trusted community members to assist us. This however, is only one aspect of our consumer empowerment strategy. We are also emphasizing person-centered approaches to patient care (e.g., patient defined goals and shared decision making), transparency of cost and quality, and the alignment of incentives to encourage and reward healthy lifestyles and effective self-care for chronic illnesses. One important question for the steering committee to consider is whether statute or regulation should be considered that would require consumer participation in the governance of the independent physician associations (IPAs), ACOs, and clinically integrated networks that will be accountable for delivering better value.

G8. Governance structure – authority, resources and expertise	Success will in great part be due to robust execution. I question whether the governance structure described will allow the state to implement SIM in a manner that achieves the strongest results. This effort along with other health initiatives needs strong coordination and support. Whether the state reinstates the Office of Health Reform or another entity, there is a pressing need for an office with the authority, resources and expertise to get the job done.	We share this goal and are receptive to specific recommendations regarding the resources and expertise that you and other steering committee members feel will be necessary for effective execution. We will be sharing more details over the next several weeks regarding the proposed initial pre-implementation office structure and future structure pending the award. As we do so, we recognize your considerable experience and expertise and would welcome your input.
G9. Attached recommendations for standards and primary care transformation		Recommendations noted.
B. Kelleher		
H1. Recommendations for alignment on standards (slide 8)	Anthem recommends payors participate in a workgroup and voluntarily adopt standards that are consistent with national vetted measures (recognizing only a subset may be adopted).	Recommendation noted.
H2. Questions related to linkage between care delivery and payment reforms (slide 18)		
a. Should timing of migration to Shared Savings Program (SSP)	Anthem agrees that migration to SSP should be decided by each payor and provider	Recommendation noted.

arrangements be decided by each payer and provider, without regard to progress on standards or AMH status?		
b. Should there be a validation survey that all existing and future providers would be required to meet as a condition for remaining in SSP arrangements?	Anthem recommends that validation should be completed by payers.	See response to B2. Some payers are receptive to a validation process might spare them from having to do their own duplicative assessments. We are proposing that the practice transformation support vendors or another co-sourced entity would assess readiness through a validation survey. Payers would have the option of accepting this validation survey, or continue to rely on their own readiness assessment. In either case, the practice is only having to demonstrate compliance with a single set of standards established under the SIM multi-payer alignment process
H3. Proposed Governance and operating model (slides 24-27), support for establishing the four proposed advisory councils/task forces and proposed composition	The proposed governance structure seems complex. While additional details of the program need to be developed, it is not clear what the ongoing roles of the Councils and Task Forces would be and what the role of the Oversight Committee/Health Care Cabinet would be. More detail would be helpful.	See responses to A3, B7, D7 and G8.

H4. Pace of payment reform assumptions (slide 31)	The pace of payment reform seems accurate although Anthem's statistics would refer to the top 12-15 groups to get to the engagement level stated.	We will amend the slide to reflect 12-15 groups.
H5. Options for scaling provider transformation support and care coordination funding (slide 32)	Anthem would like to better understand practice transformation support, the level of support envisioned and for which areas of practice transformation. For instance, is the plan to have a work group or staff supporting the practices?	The Core Team will present a straw man for practice transformation at the next steer co meeting. We will propose to use grant funds, in whole or in part, to support practice transformation support provided by qualified vendors.
H6. Other comments on the broader deck:	• Slide 15, APCD system support...APCDs are typically utilizing population based data for analysis; not clear how much overlap, even in a future state, can be achieved with this payment model which requires de-aggregated data at the patient level detail for data exchange between providers and payors.	APCDs are typically used for system-level analysis, rather than provider or patient-specific feedback. With that said, there may be an opportunity to leverage the APCD infrastructure and build a single, common analytics solution. This is consistent with the current CT APCD approach of receiving identified data, and de-identifying internally. While APCD data aggregation levels vary on a state by state basis, CT's APCD will be collecting and securely maintaining medical, pharmacy, and dental claims at a patient level, in addition to provider and eligibility information. Having this data at a de-aggregated level provides a greater opportunity to address a wide range of critical issues in health care on a statewide basis.

H7	• Anthem agrees with one payor portal. We currently use Availity and understand that other carriers have access to that portal. (I've referenced this in the HIT workgroup.)	We appreciate your support of the common provider portal, and definitely see Availity as a leading option. Your use of Availity today, and the broad usage by payers in other markets may encourage CT payers to invest in the required functionality.
	• Slide 16, regarding the glide path, Anthem plans to retain P4P programs at least through 2014 for those practices not ready for shared savings models. We will re-evaluate in 2014 based on provider engagement in value arrangements.	The payment workgroup recommendation is for all payers to provide a P4P option when the grant begins in 2015 and for several years thereafter. We would appreciate better understanding the basis for Anthem's re-evaluation in 2014.
	• Slide 20...would like more information on the Certified Community Based Entity. Who would certify and how would it be maintained? Will this entity be funded through the grant and what is funding for the longer term? It would be important to know what the role and goals of this entity are.	This will be discussed in the next steering committee meeting.
	• Slide 32, would like more information on assumptions and calculations for practice transformation and care coordination support and funding.rs	A practice transformation straw man and associated cost assumptions will be presented at the next meeting of the steering committee. The core team is proposing that the AMH standards include requirements for structures and processes associated with readiness to undertake care coordination. We would ask that payers commit to

		providing financial support once readiness is demonstrated, either through enhanced fees, advanced payments, or other method mutually agreeable to the payer and provider.
	• Slide 33, would like more information on HIT plan/what is envisioned for the amount noted. PMO investment range is very broad/high on the outside range; detail on work and funding levels would be useful.	Considerable additional work is necessary to produce the detailed scope of work and funding levels to support the various HIT objectives. This work will commence in November or December and be completed prior to the submission of the test grant.
	• Slide 34, reference to premium tax to payers. I would recommend a more detailed description of the grant spending/allocation in advance of establishing assessments to carriers for this effort. In addition, at what point in time are assessments expected to occur and what is the basis of calculation. Also, it is not clear what "ACO Self Funding" is; more information would be helpful.	Recommendation noted. ACO self-funding refers to investments in infrastructure and capabilities that might be required of the IPAs, ACOs, and clinically integrated networks to succeed in the future performance transparent and value oriented market.

Attachment

SIM Recommendation	Feedback	Rationale
1) Recommendations for alignment on standards (slide 8) - Provider Transformation Workgroup defines AMH standards and element - Payers participate in workgroup and voluntarily adopt standards - Possibly subject to attestation and verification - Reciprocity with national medical home accreditation bodies (i.e., NCQA, Joint Commission) - On-site validation survey conducted by common vendor	- Leverage existing standards in the State that are already widely used (e.g. NCQA Level 2 and Level 3 PCMH standards) rather than creating an entirely new set of standards - Within the existing available standards, select specific standards on which to focus to hone areas of special interest, as suggested by SIM leadership. For example, NCQA's most recent standards have specific health equity requirements that should be highlighted among other SIM standards/requirements. - Allow reciprocity of standards to the extent that the standards are truly equivalent (e.g. NCQA and JCAHO are not). SIM staff and stakeholders should review the equivalence of any standards that are considered. - Conduct on-site validation by a common vendor as proposed. - Have providers attest to their ability to meet and maintain standards as proposed. - Require that SIM management and	- NCQA achieved broad adoption of its' PCMH standards across the multiple stakeholder groups; NCQA standards are already widely used in Connecticut. Using existing standards will save time and effort and support more rapid system transformation. JCAHO criteria should also be reviewed - Attestation and verification of ability to meet standards is important; providers can meet a set of standards on any given day and not necessarily meet them on an ongoing basis - An approach that features centralized management of key functions can promote economies of scale across the state as well as consistency, common vision and shared expectations among providers (who contract across multiple insurers)

	staff monitor achievement and maintenance of standards, quality metrics, financial calculations and other key management functions rather than having insurers individually manage these tasks.	
2) Questions related to linkage between care delivery and payment reforms (slide 18)	We would like to understand more about the rationale for SSP vs. TCC. Regardless of whether SIM elects to use SSP vs. a TCC approach, we recommend that: - Any incentive method be standardized and managed by a central body. - Any decision regarding quality and/or cost incentives depend on the overall model and reimbursement design, which is not available at this point in time. We strongly recommend that SIM agree upon standards and the model of care prior to developing a full-blown reimbursement design with provider incentives. - A validation survey be used to ensure quality and compliance with standards of care as suggested by the SIM Team.	The model design (and appropriate quality, cost and satisfaction metrics) should proceed the reimbursement design. Reimbursement design should be driven, in part, by SIM goals and measures and the product design that will drive the greatest value (equal to cost and quality) based on the program design. These components should not be developed in isolation.
2) Proposed Governance and operating model	Rather than the informal committee	The proposed governance model

(slides 24-27), support for establishing the four proposed advisory councils/task forces and proposed composition	structure proposed to date, CT Health favors a more formal structure with paid staff within an accountable office which will manage SIM. We propose a structure that incorporates: - Accountability to an employed management team with an oversight body that will ultimately monitor value, consisting of quality and cost-effectiveness and key operational functions - Sufficient management and staff resources to conduct key aspects of the work required under SIM including but not limited to: vendor management, contracting functions, data collection, analysis and distribution, network management, health equity measurement and improvement, financial analysis, incentive payment, provider education and improvement, etc.). The informal structure, as proposed, does not appear to offer the resources or accountability needed to develop, implement and manage and initiative of this magnitude and importance - Linkages to all state agencies responsible for health care delivery with productive, collaborative	could be strengthened by dedicated management and staff to conduct the plethora of work that will be required to successfully transform the delivery system in Connecticut. Accountability of ongoing work product and results are critical to the success of the SIM initiative. Advisory councils can function with staff support and ensure broad-based input from a range of stakeholders.

	relationships - Advisory council functions with staff support from the entity that houses employees responsible for SIM functions listed above - A Project Management Office (PMO) within a newly created agency or division responsible for SIM. The PMO should employ content experts rather than process-oriented project managers	
4) Pace of payment reform assumptions (slide 31)	- What is the basis of this statement? What is the experience in other states or, in the private market? - Where are the small practices with 1, 2 and 3 providers which are a predominant form of practice in Connecticut? How will they link to payment reform efforts and in what timeframe?	

5) Options for scaling provider transformation support and care coordination funding (slide 32)	We believe that key drivers of system-wide change include provider education, data, and support to purchase, adopt and fully utilize Electronic Medical Records. The availability of provider resources and training within the SIM model is unclear. Furthermore, care coordination is a key component of the model; however, the care delivery model has not been adequately described to date.	Change cannot occur without sufficient provider education, data and support. Funding is only one component of success and would ordinarily be driven by a multitude of factors.